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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 12, 2009

Cliff McAleer
Milestone Decisions Inc #3 Lexington
611 South Main
Moscow, ID 83843

RE: Milestone Decisions Inc #3 Lexington, provider #13G044

Dear Mr. McAleer:

This is to advise you of the findings of the Medicaid/Licensure survey of Milestone Decisions Inc #3 Lexington, which was conducted on November 6, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 25, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by November 25, 2009. If a request for informal dispute resolution is received after November 25, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G044	A. BUILDING _____ B. WING _____	11/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS INC #3 LEXINGTON	2087 LEXINGTON AVENUE MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiency was cited during the annual recertification survey. The survey was conducted by: Matt Hauser, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED NOV 23 2009 FACILITY STAN...	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure outside services met the needs and were sufficiently coordinated and monitored for 1 of 1 individuals (Individual #1) who attended outside day treatment programs. This resulted in outside services not being sufficiently coordinated. The findings include: 1. Individual #1's 3/4/09 IPP stated he was of school age and his diagnoses included severe mental retardation. a. An observation was conducted at Individual #1's school on 11/4/09 from 9:45 - 10:55 a.m. During that time, Individual #1's teacher was interviewed. When asked, the teacher stated the school had not been provided with any	W 120	see attatched plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
C Matt McAtee	Administrator	11-20-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 information regarding medication Individual #1 received. The teacher stated she had received no training programs or behavior programs from the facility for Individual #1. The teacher did state she had the QMRP's contact information, and had met briefly with the QMRP. When asked how she intervened if Individual #1 attempted to eat non-food items she stated Individual #1 had attempted to eat non-food items (a small glass heart) and the school implemented their own interventions and had not been provided with any interventions from the facility. When asked how information about Individual #1's eating or attempting to eat non-food items would get to the facility, the teacher stated it would not because the school had no way of sharing information with the facility. During the 11/4/09 observation from 10:04 - 10:20 a.m., Individual #1 was observed performing shredding with an aid employed by the school. The aid provided Individual #1 with gestural and physical prompts throughout the shredding task and was observed periodically providing Individual #1 with edible reinforcers. After the shredding task was complete the aid was interviewed at 10:38 a.m. When asked if Individual #1 ate non-food items, the aid stated that he would eat anything if he can get it to his mouth. The aid stated that Individual #1 had ingested the "pull tab from a zipper the other day." The aid added that due to his oversight, the ingestion of the pull tab from the zipper had not been reported to anyone. When asked if the facility had provided training on how to intervene when Individual #1 attempted to ingest non-food items, the aid stated they had not.	W 120		

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W 120	Continued From page 2 The teacher was asked for any and all written information she had regarding Individual #1 on 11/4/09 at 10:45 a.m. The teacher produced a folder with Individual #1's Individual Education Plan (IED). The folder contained no information from the facility and no information about Individual #1 ingesting or mouthing non-food items or the use of edible reinforcements. When asked if edible reinforcers were to used the teacher stated she did not use edible reinforcers with Individual #1 but was aware the aid did. When asked, the QMRP stated during an interview on 11/5/09 from 3:30 - 4:00 p.m., Individual #1 had ingested non-food items on two occasions. The QMRP stated he did not have a copy of Individual #1's IEP from school and had not been invited to the schools IEP planning meeting. When asked about the use of edible reinforcements, the QMRP stated that he was aware the school had made use of them but added using edible reinforcements in the facility was extremely rare. The QMRP stated the school did not have Individual #1's IPP or any written training programs used by the facility. When asked if there were any specific protocols related to Individual #1 ingesting or attempting to ingest non-food items, the QMRP stated there were not. Without information related to Individual #1's training objectives, behavioral issues, or a way to communicate information regarding his status at the school, the facility would be unable to adequately ensure that consistent coordination with the school occurred for Individual #1.	W 120		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiency was cited during the annual licensing survey. The survey was conducted by: Matt Hauser, QMRP, Team Leader Jim Troutfetter, QMRP	M 000	RECEIVED NOV 23 2009	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859	refer to W-120 plan of correction	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-20-09

Plan of Correction
Milestone Decisions Inc. #3 Lexington
Provider # 13G004

W120 The facility will assure the outside services meet the needs of all individuals receiving outside services at this home. The group home administrator will facilitate the flow of information between the facility and the outside service for all written and verbal communication to include; face to face meeting, phone calls, e-mails communication log, all pertinent facility paperwork, all pertinent paperwork from the outside services.

Milestone Decisions Administrator will monitor by receiving report from Group Home Administrator at the beginning of each semester or twice annually.

Deficiency and plan of corrected were completed on 11-17-09

MM859- Refer to W-312